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No. 84-1157

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1984

NKC HOSPITALS, INC. - - - - Petitioner

versus

MARGARET M. HECKLER, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES - Respondent

On Petition for Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

SUPPLEMENTAL AND REPLY BRIEF FOR THE PETITIONER

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v.

MARGARET M. HECKLER, Secretary, United States Department of Health & Human Services - - *Respondent*

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

SUPPLEMENTAL AND REPLY BRIEF FOR THE PETITIONER

ARGUMENT

On February 15, 1985 the United States District Court for the District of Columbia granted summary judgment to the plaintiff in *Greater Southeast Community Hospital* v. *Margaret Heckler,* No. 84-2951 (D.D.C. Feb. 15, 1985). This brief will discuss the *Greater Southeast* decision with respect to the Secretary's interpretation and application of 42 C.F.R. §405.452(d)(10)(1977) to NKC Hospitals, Inc.'s[1]

[1]See footnote, p. 1 of Petition for Writ of Certiorari, and correspondence to Ms. Loretta Ruffin, Assistant Clerk, U.S. Supreme Court, dated January 24, 1985 for disclosure of corporate affiliations and financial interest.

Transitional Care Unit ("TCU"), and reply to the Respondent's brief in opposition.

The focus of the District Court opinion in *Greater Southeast* is a comparison of the hospital's Intermediate Care Unit ("IMC") with its recognized special care units, an intensive care and a coronary care unit. The level of care provided by the IMC is analyzed in terms of nurse to patient ratios, nursing hours per patient day, costs per patient day, and admittance patterns. In each category of this factual inquiry the Petitioner's TCU compares favorably with the four recognized special care units in its own facility.

The statistics regarding the level of nursing care cited by the Court in the *Greater Southeast* decision reflect "almost identical" nurse/patient ratios among the intermediate, intensive, and coronary care units. The study of the Petitioner's TCU showed the nursing hours in that unit to be closer to those in the coronary care unit than the same comparison made between the coronary and intensive care units. (Petitioner's App. 28a).

The reference to the costs per patient day in the *Greater Southeast* opinion states that the costs in the IMC are "comparable" to those in the two recognized special care units. The same test applied to the Petitioner's TCU with respect to its four recognized special care units shows that the costs in the TCU represent 103.9% and 120% of the nursing costs per day in the neonatal and coronary care units, respectively. (Pet. App. 35a). A comparison of non-nursing costs per day between the TCU and the cor-

onary care unit shows that these costs in the TCU were 25% higher in 1977 and 69.6% higher in 1978 than the same costs in the coronary care unit. (Record, p. 78). A comparison of the per diem costs among the five units also reveals that the TCU exceeds the per diem in two of the four recognized special care units. (Pet. App. 35a). Thus, the evidence in the record is much stronger in this area of comparison for the Petitioner's TCU than that before the Court in *Greater Southeast.*

The Court mentioned that approximately 40% of the admissions to the IMC were from the intensive and coronary care units in the *Greater Southeast* case. In the case at bar, 49% of the patients came to the TCU from the other special care units. Rather than supporting the Secretary's contention that the IMC was a "stepdown" unit, the Court found this alone proved little in light of evidence showing that patients in the intermediate care unit were receiving the "extraordinary, concentrated and continuous" care required by regulation.

The Court also looked at the written guidelines for the IMC, as did the Secretary in the instant case. Noting that the guidelines did provide "some support" for the contention that the IMC could have served as a stepdown unit, the *Greater Southeast* Court ruled, however, that "written guidelines cannot substitute for testimony as to what actually occurred in the unit to determine how the unit functioned in fact as opposed to on paper." Yet this substitution is exactly what took place in the instant case. (Respondent's Brief, p. 8).

Finally, the *Greater Southeast* Court pointed out that the nursing director of the IMC and a physician testified that there was no significant difference between the IMC and the recognized special care units in terms of intensity of care, nurse training and skills, and equipment availability, among other factors. Substantial evidence in the record of the case at bar indicates the same lack of differentiation among the special care units at the Petitioner's facility. (Record, Board Hearing, vol. one, pp. 40-41, 44; vol. two, pp. 86-89; Flynn depo. pp. 15-17, 26, 28 ff. p. 120 of Board Hearing; Record, pp. 93, 99, 171).

The Respondent makes several references in her brief to the substantial evidence supporting the Secretary's decision in the case at bar. For example, she points out that the visiting hours for the Petitioner's TCU were considerably more liberal than visiting hours in the coronary and intensive care units. (Resp. Brief, p. 8). The Secretary went so far as to state that visiting hours of the TCU were more liberal than those in the "established" special care units. (Pet. App. 26a). Yet the record established at the Provider Reimbursement Review Board ("Board") showed that although the visiting hours for two special care units, the intensive care and neonatal units, were more restrictive than those in the TCU, the coronary care and burn units had *more* liberal visiting policies than the TCU. (Record, pp. 88, 121, 126, 261, and 273).

In addition, the Respondent states that the level of patient monitoring in the TCU was considerably less extensive than that in the coronary care unit. (Resp.

Brief, p. 8). Once again, the record established at the Board specified that the only area in the hospital which had telemetry monitoring available for cardiac patients was the TCU. Even the coronary care unit, which services only cardiac patients, does not utilize telemetry monitoring. (Record, Board Hearing, vol. one, pp. 34-35).

The *Greater Southeast* decision demonstrates the importance of examining all the factual criteria with reference to the application of 42 C.F.R. §405.452(d)(10)(1977). The Court must analyze the Petitioner's TCU in light of *all* of the facility's special care units, not, as Respondent has done, select data to fit her view of substantial evidence.

CONCLUSION

The decision of *Greater Southeast Community Hospital* v. *Margaret Heckler* demonstrates that a searching analysis of the record in the case at bar will support a finding that there was a lack of substantial evidence in the Secretary's interpretation and application of 42 C.F.R. §405.452(d)(10)(1977) with respect to the Petitioner's Transitional Care Unit.

The Petitioner, therefore, respectfully requests that the Court address the issues set forth herein and in its Petition, and grant the Petition for Writ of Certiorari.

Respectfully submitted,

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APPENDIX

IN THE

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF COLUMBIA

Civil Action No. 84-2951

GREATER SOUTHEAST COMMUNITY HOSPITAL, - \ *Plaintiff,*

v.

MARGARET HECKLER, Secretary of
Health and Human Services, - - - *Defendant.*

MEMORANDUM — Filed February 15, 1985

This Medicare reimbursement dispute is before the Court on appeal from a denial by the Provider Reimbursement Review Board (the Board) of two categories of cost claimed by plaintiff.[1] Defendant has moved for judgment on the pleadings and plaintiff has cross-moved for summary judgment. The issues have been fully briefed and argued by counsel.

The hospital is challenging the Board's refusal (1) to allow certain interest expenses on funds borrowed for capital improvement as eligible for Medicare reimbursement in fiscal years 1977 through 1980, and (2) to treat the

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[1]The Board's decision became final agency action by virtue of the decision of the deputy administrator of the Health Care Financing Administration not to reverse, affirm or modify the Board's decision. The Court has jurisdiction under 42 U.S.C. § 1395oo(f) to determine whether based on the administrative record, the agency action was arbitrary, capricious, an abuse of discretion, unsupported by substantial evidence, or otherwise not in accordance with law. *See Psychiatric Institute of Washington, D.C., Inc.* v. *Schweiker,* 669 F. 2d 812 (D.C. Cir. 1981).

hospital's intermediate care unit as a special care unit entitled to higher reimbursement than routine care units in fiscal years 1977, 1978 and 1980.

I. Interest Expense

Part of the hospital's claimed interest expense on capital loans was disallowed for the years in question on the basis that the hospital engaged in excessive borrowing because it did not use available funded depreciation in lieu of part of the loans obtained.

The hospital engaged in extensive construction and renovation between 1974 and 1982. It obtained two commercial loans in 1976 and 1978, with total long-term borrowing totaling approximately $6.1 million, and financed the rest of the capital improvements with approximately $3.5 million of internal funds.

Medicare generally requires hospitals to use funded depreciation for capital projects before obtaining external borrowing.[2] A limited discretionary exception to this rule developed by the case law permits the Secretary to allow hospitals and other Medicare providers to defer using the depreciation account until the end of a multi-phased construction project, so that the hospital can obtain better terms on loans at the start of the project.

The Board found that the hospital here had not engaged in a single planned program of multi-phased construction but instead had engaged in a variety of separate related

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[2]Medicare regulations generally provide that interest expense is reimbursable if it is "necessary and proper." 42 C.F.R. § 405.419(a). Medicare encourages providers to establish "funded depreciation" accounts to be used for capital expenditures. 42 C.F.R. § 405.415(e). To the extent that a provider has funded depreciation available for capital projects, external borrowing is generally considered not necessary. *See* Medicare Provider Reimbursement Manual § 226.

projects. This finding is supported by substantial evidence and so cannot be overturned. The hospital is unable to point to any master plan, single certificate of need, board minutes or other comprehensive documentation showing that at the outset its board of directors contemplated a phased program of construction in which use of funded depreciation would be deliberately put off until the latter years. The available documentation shows that only by post-hoc rationalizations can one conclude that there was a phased program of construction and financing.

In addition, the hospital transferred part of its funded depreciation to its foundation to be used for nursing home construction. The Board reasonably found that this was inconsistent with the purpose of the regulations concerning funded depreciation.

Accordingly, the Court finds no reason to upset the Board's finding on the interest expense disallowances. The Secretary's motion for judgment on the pleadings on this issue is granted and the plaintiff's motion for summary judgment is denied.

II. Intermediate Care Unit

The hospital's argument that the Board should have treated its intermediate care unit as a special care unit is more troublesome. To qualify as a special care unit, the hospital must show that, among other things, the unit is one "in which the care required is extraordinary and on a concentrated and continuous basis . . . ." 42 C.F.R. § 405.452(d)(10)(1978).[3] The parties agree that the primary focus of inquiry in this instance is whether the unit is similar to or comparable to the hospital's already recog-

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[3]The Health Care Financing Administration's interpretation of these terms can be found in *Creighton Omaha Regional Health Care Corp.* v. *Mutual of Omaha Ins. Co.*, 1982 Medicare and Medicaid Guide (CCH) ¶ 32,134 at 10,452-53.

nized special care units (the coronary care and intensive care units). *See Villa View Community Hospital, Inc.* v. *Heckler,* 728 F. 2d 539, 541-42 (D.C. Cir. 1984); *Psychiatric Institute of Washington, D.C., Inc.* v. *Schweiker,* 669 F. 2d 812, 814 (D.C. Cir. 1981). This is a factual inquiry turning on the evidence in the record.

The hospital points out that the level of nursing care in its intermediate unit was statistically quite similar to that in its recognized intensive care and coronary care units. Nurse/patient ratios were almost identical, and nursing hours per patient day in the intermediate unit were 88 per cent of those rendered in the recognized special care units, while nursing hours in routine care areas of the hospital amounted to only 32 per cent of the hours in the special care units. Costs per patient day also were comparable between the intermediate unit and the special care units.

The Board discounts these similarities, noting primarily that nursing hours in the intermediate unit included hours of cardiac monitoring technicians. The hospital's testimony was that these technicians perform the same monitoring tasks that nurses perform in the recognized special care units. The Board has offered no justification for why the definition of nursing care should not include direct patient care rendered by specially trained skilled technicians even though they are not registered nurses. In addition, monitor technician time has been included in calculations of the level of nursing care in other cases. *E. g., Creighton Omaha Regional Health Care Corp.* v. *Mutual of Omaha Ins. Co.,* 1982 Medicare and Medicaid Guide (CCH) ¶ 32,134 at 10,453. That is because the proper distinction in determining nursing hours is between hours devoted to direct patient care and hours devoted to other, non-nursing tasks (such as clerical work). The Court concludes that this factor cannot justify the Board's decision.

The hospital also offered extensive testimony from the nursing director of the intermediate unit and from a physician. The physician had admitted numerous patients to both the intermediate unit and the special care units and was a member of the hospital's critical care committee overseeing its special units. They offered uncontradicted testimony that the intermediate unit, while it may have originally been planned as a "stepdown" unit offering convalescent care, served primarily as an overflow unit for the recognized special care units. These witnesses testified that there was no significant difference between the intermediate unit and the recognized special care units in intensity of care, nurse training and skills, equipment availability or other important factors. The Board made no credibility findings against these witnesses but apparently disregarded their testimony.

There is no substantial evidence to support the finding that the intermediate care unit served in fact as a stepdown unit. The Board relied on the fact that approximately 40 per cent of the admissions to the intermediate unit were from the recognized special care units. This was said to support the contention that it served as a stepdown unit. This statistic alone proves little in the face of the other evidence showing that patients in the intermediate unit were subject to continuous monitoring and in other respects received the requisite "extraordinary, concentrated and continuous" care.

Finally, the Board concluded that the hospital had failed to show that it had written guidelines for the unit for the fiscal years in question, as required by the regulation. However, the uncontradicted testimony was that written guidelines were kept but were updated each year and the old guidelines were thrown out. Guidelines for a later year were presented and competent witnesses testified they were substantially identical to the guidelines for

the years at issue. These guidelines clearly applied specifically to the intermediate unit, as required by the regulation. While they provide some support for the contention that the unit in some respects could have served as a stepdown, the written guidelines cannot substitute for testimony as to what actually occurred in the unit to determine how the unit functioned in fact as opposed to on paper.

The substantial evidence test applicable in cases such as this does not require that the weight of the evidence support the Secretary's decision. However, "[a]t a minimum . . . a decision is not supported by substantial evidence unless there is 'such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.'" *Airport Shuttle Service, Inc.* v. *ICC,* 676 F. 2d 836, 840 (D.C. Cir. 1982). Based on the record here and the foregoing analysis, the Court is of the firm view that the Board's disallowance of the intermediate care unit does not meet this standard when viewed in light of the applicable regulations. When one focuses on how the unit actually functioned, it is apparent that it provided virtually the same intensity of services as those given on the recognized special care units. Accordingly, the plaintiff's motion for summary judgment on this issue is granted and the defendant's motion is denied.

An appropriate Order is filed herewith.

(s) Gerhard A. Gesell
United States District Judge

February 15, 1985